STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 00 B. WING	02/17/2012

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 13, 14, 15, 16, and 17, 2012. Facility number: 000079 Provider number: 155159 AIM number: 100266160 Survey team: Rick Blain, RN- TC Sue Brooker, RD Diane Nilson, RN Angela Strass, RN Census bed type: SNF/NF: 46 Total: 46 Census payor type: Medicare: 3 Medicaid: 34 Other: 9 Total: 46 Stage 2 sample: 27 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of defciencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 3-18-12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	22, 2012 by Bev Faulkner, RN			

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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide documentation indicating two days notice was provided regarding pending Medicare non-coverage for 2 of 3 residents (Resident #42 and Resident #47) reviewed for notification of Medicare non-coverage. Findings include: On 2/15/12 at 2:00 P.M., three Notices of Medicare Non-Coverage were received and reviewed. 1. A "Notice of Medicare Provider Non-Coverage" form for Resident #42 indicated "The effective date coverage of your current outpatient	F0156	It is the intent of this community to inform residents and family members of their rights both orally and in written format. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**The IDT team will review and discuss daily during morning meeting all residents pending notifications. **What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?** A mandatory in-service for all management team members will be conducted on or before March 16, 2012. This in-service will be conducted by the SS consultant in order to ensure proper direction of notification guidelines. This verification process will esure that all proper notifications will be in	03/18/2012

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	rehabilitation services will end: October 7, 2011." The form indicated Resident #42 signed and dated the form on 10/6/11, indicating she had received the notice on that date. 2. A "Notice of Medicare Provider Non-Coverage" form for Resident #47 indicated "The effective date coverage of your current outpatient rehabilitation services will end: September, 30, 2011." A handwritten note on the back of the form indicated the resident's Power of Attorney (POA) had received notice of the non-coverage on 9/30/11 by telephone and had signed the form on 10/3/11. The facility's Executive Director (ED) was interviewed on 2/16/12 at 10:15 am. During the interview, the ED indicated the facility did not have a policy regarding the provision of the "Notice of Medicare Non-Coverage" information to residents or their POA's, but the facility followed the regulations and a minimum of two days notice should have been provided. 3.1-4(f)(3)		place before the changes of services. The medical records personnel will verify that all paper work is completed in a timely fashion in compliance. **How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?** The IDT team will monitor resident notifications on a a daily basis to identify the potential for deficient practices. To ensure compliance, the Executive Director/designee will be responsible for completion of the CQI tool weekly x 4 weeks, bimonthly times 2 months, and then quarterly until compliance is maintained for 2 consecutive quarters. The results will be reviewed by CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F0252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation, interview, and record review, the facility failed to ensure a wheelchair pressure pad was free from odor for 1 of 2 residents who met the criteria for incontinence in a stage 2 sample of 27 residents (Resident #27). Findings include: 1. Resident #27 was observed sitting in a wheelchair, in her room, at 2:40 P.M. on 2/13/12. A puddle of yellowish/brown liquid was noted on the floor under the wheelchair. Two CNA's, #12 and #20, indicated they were going to provide incontinence care to the resident, who they indicated had been incontinent. When the two CNAs stood the resident up, the back of the resident's pants were saturated and the wheelchair pad in the resident's wheelchair was noted to have a soiled wet area on it. In interview, CNA #20 indicated the resident had been having loose stools.	F0252	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The chair belonging to Resident #27 was cleaned immediately to include the wheelchair cushion. All wheelchairs and cushions were cleaned immediately and then daily according to wheelchair cleaning schedule.WC and WC cushion cleaning schedule implemented on 3rd shift and all clinical nursing staff educated on importance of ensuring cleanliness of adaptive equipment.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**All residents that transport with wheelchairs have the potential for soiled cushions accompanied by odor. Clinical nursing staff will identify such potential by cleaning wheelchairs by schedule and as needed. A Post test will be given to assess understanding.**What measures will be put in place or what systemic changes will you make to ensure that the**	03/18/2012

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	The Resident #27's record was reviewed on the morning of 2/16/12. The Minimum Data Set assessment, dated 11/28/11, indicated the resident was cognitively impaired, with short and long term memory impairment, required extensive to total assistance with activities of daily living care, and was incontinent of bowel and bladder. On 2/16/12, at 9:35 A.M., a urine odor was noted in the resident's room, and the pressure pad in the resident's wheelchair was noted to have an odor of urine. LPN #22 came into the resident's room and confirmed the pad in the wheelchair had an odor. On 2/16/12, at 9:57 A.M., Physical Therapy Assistant #23 was observed placing a new pad in the wheelchair and in interview indicated LPN #22 had requested a new pad. Review of the 3rd shift duties form, provided by the Assistant Director of Nursing Services, on 2/16/12 at 12:16 P.M., indicated wheelchairs and cushions were to be deep cleaned every Thursday. 3.1-19(f)(5)		**deficient practice does not recur?** DNS/designee will in-service all nursing staff on WC cleaning. 3rd shift staff will follow wheel chair cleaning schedule due to most/all residents are in bed during this period. If residents are awake and transporting via wheelchairs, additional cushions are available until cushions are dry and ready for use. Charge nurses will monitor wheelchair cleaning for compliance daily.**How will the corrective action be monitored to ensure that the deficient practice will not recur?** 3rd shift nurses and certified nursing assistants will sign wheelchair cleaning sheets daily and turn in with 24 hour report. Logs will be monitored 5xs a week DNS/designee will monitor the wheelchair CQI log daily x 1 month, twice weekly x 3 months, and weekly x3 months, ending with quarterly checks until compliance is maintained for two consecutive quarters. A post test will be given to check for understanding.Data will be submitted to CQI committee for review and follow up on a monthly basis until compliance. A compliance threshold of 95% will be used to determine continued monitoring and an action plan will be developed to ensure compliance. Non compliance may result in disciplinary action up to and including termination.	

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to asses and ensure 2 of 3 residents randomly observed (Resident #26 and Resident #14) during dining were positioned safely in the Stage 2 sample of 27. Findings include: 1. Review of the clinical record for Resident #26 on 2/15/12 at 3:00 p.m., indicated the following: diagnoses included, but were not limited to, organic psychotic conditions, dementia with psychotic/agitated features, depression, Alzheimer's dementia, seizures, and Picks disease. Nursing Progress Notes for Resident #26, dated 1/22/12, indicated he was admitted to a local hospital with a fractured left hip. Nursing Progress Notes for Resident #26, dated 1/27/12, indicated he was	F0309	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Residents #26 and #14 were re-evaluated by therapy services for accurate positioning for feeding to ensure resident's safety. Resident #26 now able to withstand a higher degree of positioning and clinical nursing staff now aware of positioning. New adjustable tables have been purchased. Resident #14 is seated at adjustable table in custom-fitted wheelchair specific to resident's statute. A regular chair is not specific to her statute and therefore resident will remain in wheelchair during dining services. Both Resident's care plan and CNA assignment guides have been updated to reflect the residents current status. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with decreased ROM, muscular rigidity, and decreased sitting	03/18/2012

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	re-admitted to the facility. A physician's order for Resident #26, dated 1/27/12, indicated for Speech Therapy to evaluate and treat. A physician's order for Resident #26, dated 1/28/12, indicated to discontinue the speech therapy order. The physician's order indicated speech therapy was not indicated at this time. A physician's order for Resident #26, dated 1/28/12, indicated physical therapy to evaluate and treat as indicated. The physician's order also indicated physical therapy to receive skilled physical therapy services 5 x/wk (times per week) x 8 wks. Treatment may include therapy activities, neuro-muscular re-education, pain management, and caregiver/staff training as needed. A Therapy Care Plan for Resident #26, with a start date of 1/28/12, indicated the problem areas of increased pain, decreased bed mobility, decreased left hip ROM (range of motion), and decreased sitting tolerance. Goals to the problems included, but were not limited to, be able to sit up in wheelchair for 2-3 hours without		tolerance are assessed for safety while dining. All staff re-educated to identify risk factors associated with residents with decreased ROM and rigidity with postural disturbances by DNS/designee.**What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?** All Staff including clinical staff and department managers will be re-educated by DNS/designee via in-services on proper assessment of residents at risk for safety hazards relating to positioning while eating. All Staff members to observe for tilted head or improper posturing during dining services. Staff to alert DNS/designee and/or therapy services immediately if risks exist that may impair safety while eating. Charge nurses will immediately correct improper positioning demonstrated during dining services.Manager in DR during meal times will monitor for improper positioning and refer to DNS and/or Manager of Therapy services. Therapy manager will communicate daily on any therapy issues or current treatment that may influence nursing care.**How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?** A CQI meal service observation Log will be monitored	

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	pain/discomfort. A Physical Therapy Plan of Treatment for Resident #26, with an onset date of 1/22/12, indicated he exhibited hypertonicity, stiffness and pain while positioned at 45 degrees in the cardiac chair for 30 minutes. A Physical Therapy Progress Report for Resident #26, dated 1/28/12 - 2/3/12, indicated he exhibited hypertonicity, stiffness and pain while positioned at 60 degrees in the cardiac chair for 60 minutes. A Physical Therapy Progress Report for Resident #26, dated 2/4/12 - 2/10/12, indicated he exhibited hypertonicity, stiffness and pain while positioned at 70 degrees while seated in the cardiac chair for 2 hours. A facility care plan for Resident #26, with a start date of 2/6/12, indicated the problem area of self care deficit related to Alzheimer's dementia and recent hip fracture. Approaches to the problem included, but were not limited to, cardiac chair when up and fed per staff. A physician's order for Resident #26, dated 1/31/12, indicated a Regular Diet.		daily x 1 month, twice weekly x 3 months, and weekly x3 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters by DNS/designee. Data will be submitted to CQI committee for review and follow- up on monthly basis. The results of these audits will be reviewed by the CQI committee overseen by the ED. Noncompliance may result in disciplinary actions.DNS/designee will be responsible for program compliance. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	During an observation of the lunch meal in the second floor dining room on 2/13/12 at 12:25 p.m., Resident #26 was observed in the dining room reclined back approximately 30 degrees above horizontal with his neck hyper-extended to the back in his cardiac chair. CNA (Certified Nursing Assistant) #9 was observed to feed him several bites of food with Resident #26 in this position before raising his cardiac chair to approximately 60 degrees above horizontal. His neck remained hyper-extended toward the back of the chair as CNA #9 continued to feed him his lunch meal. During an observation of the lunch meal in the second floor dining room on 2/15/12 at 12:10 p.m., Resident #26 was observed in the dining room reclined back approximately 30 degrees above horizontal with a pillow behind his head in his cardiac chair. CNA #10 was observed to give him several bites of food with Resident #26 in this position before raising his cardiac chair to approximately 60 degrees above horizontal. His head remained reclined with his mouth facing toward the ceiling. CNA #10 was then observed to offer him a glass of juice by bringing the full glass			

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	to his mouth with his head still tilted back. She then was observed to put a straw into his glass and offer him a drink. CNA #10 continued feeding Resident #26 by placing his eating utensil into his mouth at an angle toward the back of his throat. During an observation of the breakfast meal on 2/16/12 at 8:25 a.m., Resident #26 was observed being fed by CNA #11 in his bed. His bed was inclined approximately 45 degrees above horizontal with his mouth facing toward the ceiling. CNA #11 was observed standing to feed Resident #26. CNA #11 continued feeding Resident #26 by placing his eating utensil into his mouth at an angle toward the back of his throat. During an observation of the lunch meal in the second floor dining room on 2/16/12 at 12:15 p.m., Resident #26 was observed in the second floor dining room reclined back approximately 30 degrees above horizontal with a pillow behind his head in his cardiac chair. CNA #12 was observed to raise his cardiac chair to approximately 45 degrees above horizontal. His head remained reclined with his mouth facing toward the ceiling. She was standing on his right side and fed him by reaching			

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SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

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	and crossing her hand over his mouth. CNA #12 continued feeding Resident #26 by placing his eating utensil into his mouth at an angle toward the back of his throat. Physical Therapist #6 was interviewed on 2/16/12 at 1:50 p.m. During the interview he indicated therapy had not been asked to assess Resident #26's positioning during dining. He also indicated Resident #26's muscles were becoming hypertonic and at times his natural posture was to hold his head back. He further indicated 45 degrees was the minimum posture recommended, but he was safe to be at 75 degrees. Resident 26's posture could be more upright if staff elevated him slowly. Speech Therapist #12 was interviewed on 2/16/12 at 4:15 p.m. During the interview, she indicated she had not received a request from the facility to assess the safety of Resident #26 during dining since he had been sitting in the cardiac chair for meals instead of a regular dining chair. She also indicated she had observed Resident #26 and wondered how he managed to eat safely with his head tilted so far back. She further indicated residents should			

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	be as upright as possible while eating. RN #17 was interviewed on 2/17/12 at 10:05 a.m. During the interview, she indicated therapy was to communicate with nursing concerning any recommendations or changes for a resident. LPN #7 was interviewed on 2/17/12 on 10:40 a.m. During the interview, she indicated CNA care sheets were used by nursing personnel to determine what each resident required. A current CNA care sheet for Resident #26, provided by the Director of Nursing on 2/17/12 at 11:00 a.m., indicated he was to be fed by staff, but did not indicate how he was to be positioned in his cardiac chair for meals. A current facility policy "Morning Meetings," dated 6/10, indicated "...To review all pertinent facility information as a team to ensure appropriate follow-up and continuity of care...Areas to be reviewed at morning meeting:...24 hour condition report...." LPN #7 was interviewed on 2/17/12 on 10:45 a.m. During the interview, she indicated the morning meeting was used to discuss significant			

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	changes and the progress of residents and determine what disciplines should be involved in assessments/re-assessments. 2. Review of the clinical record for Resident #14 on 2/15/12 at 2:12 p.m., indicated the following: diagnoses included, but were not limited to, organic brain syndrome, Alzheimer's disease, decreased appetite, and history of depression. During an observation of the lunch meal on 2/13/12 at 11:50 a.m., Resident #14 was observed sitting at a dining table in the second floor dining room eating her lunch. She had been transferred from her pediatric wheelchair into a regular dining chair. Due to her short stature her feet were observed dangling approximately 2 inches above the floor without any support under her feet to stabilize her posture. Her back was not touching the back of the chair and she was observed to be leaning into the table. During an observation of the breakfast meal on 2/15/12 at 7:45 a.m., Resident #14 was observed sitting at a dining table in the second floor dining room eating her breakfast. She had been transferred from her			

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	pediatric wheelchair into a regular dining chair. Due to her short stature her feet were observed dangling approximately 2 inches above the floor without any support under her feet to stabilize her posture. Her back was not touching the back of the chair and she was observed to be leaning into the table. During an observation of the lunch meal on 2/15/12 at 12:00 p.m., Resident #14 was observed sitting at a dining table in the second floor dining room eating her breakfast. She had been transferred from her pediatric wheelchair into a regular dining chair. Due to her short stature her feet were observed dangling approximately 2 inches above the floor without any support under her feet to stabilize her posture. Her back was not touching the back of the chair and she was observed to be leaning into the table. During an observation of the lunch meal on 2/16/12 at 12:05 p.m., Resident #14 was observed sitting at a dining table in the second floor dining room eating her breakfast. She had been transferred from her pediatric wheelchair into a regular dining chair. Due to her short stature her feet were observed dangling			

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	approximately 2 inches above the floor without any support under her feet to stabilize her posture. Her back was not touching the back of the chair and she was observed to be leaning into the table. Certified Occupational Therapy Assistant #2 was interviewed on 2/16/12 at 1:58 p.m. She indicated Resident #14 had a pediatric wheelchair due to her small stature. She also indicated her feet touched the ground when she was in her wheelchair and support should be under her feet at the dining table. She further indicated therapy received referrals from the nursing department to evaluate a resident for positioning. A current facility policy "Meal Service and Distribution", revised on 4/11, indicated "...Dining room tables should be adequate in height to accommodate the resident's needs...." The policy did not indicate a resident's feet should have adequate support to maintain posture. 3.1-37(a)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer, resulting in a painful open area in the palm of the hand for 1 of 1 randomly observed residents in a stage 2 sample of 27 residents (Resident #2). Findings include: 1. Resident #2 was interviewed, at 11:00 a.m., on 2/13/12, and indicated she was having pain in her hands, stomach, and buttocks, and was receiving pain medication every 4 hours, which helped "a little." Both of the resident's hands were observed to be contracted. The left hand was worse and observed balled into a fist. There were no splints noted in place. On 2/13/12, at 3:30 p.m., the resident was heard calling out for the	F0314	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #2 is receiving proper wound care and splinting care. The resident's care plan and care guide has been updated to reflect resident's current condition.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with hand contractures were assessed for risk factors. All residents with hand contractures will be assessed and charted on daily by nurses each shift. Resident's care plan and Certified Nursing Aide care guide plan has been updated to reflect residents current status.**What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not**	03/18/2012

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	nurse. The resident was lying in her bed, with the call light noted lying on the bed beside her left hand. The resident indicated she was not able to turn on the call light due to the contractures in her hands, and indicated her hands "hurt real bad" and she wanted to go to the hospital. At this time, LPN #40 came into the resident's room and the resident requested pain medication . During medication pass, at 9:10 a.m., on 2/15/12, with LPN#1, the LPN was observed passing medications to Resident #2. The resident indicated her left hand hurt. Both the resident's hands were noted to be in fists with the left worse then the right. An odor was noted to both of the resident's hands. LPN #1 confirmed there was an odor to the resident's hands and the nurse attempted to open the resident's hands slightly, but could not open them. The LPN indicated she had not taken care of the resident for awhile, as the resident had been on a different floor, and moved recently, but indicated the resident used to get occupational therapy and wore splints on her hands. The nurse indicated she didn't know how the CNAS washed the resident's hands.		**recur?** All licensed nursing staff will be in-serviced by DNS/designee on proper assessment and documentation of contractures. Documentation will be done daily x 3 months and then resuming a weekly assessment as indicated by policy. A Post test will be given during this in-service. Certified Nursing Assistants will be in-serviced to educate on proper care and observation of residents with splints. A post test will be given to Certified Nursing Assistants. An In-service by Therapy to Restorative Aides on splinting care will also be done to include a post test. All assessments and monitoring by nursing staff will include pain control, nail care, and overall ADL care of residents with the potential of the same deficient practice. Therapy manager will communicate daily with Nursing leaders any current treatment that may influence nursing care.**How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?** A Range of Motion CQI Log will be monitored daily x 1 month, weekly x 5 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters by DNS/desgnee.MDS coordinator to check restorative-aides documentation of application of splints daily	

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	The resident was questioned at this time, and indicated they didn't wash her hands. CNA #3 was interviewed at 10:30 a.m., on 2/15/12, and indicated he was taking care of Resident #2 and she was scheduled for a bath today. The CNA indicated it was difficult to wash the resident's hands because they were so contracted and the resident couldn't open her hands. He indicated the resident used to wear a splint of some kind, but he hadn't seen her wear it lately. While talking with the CNA, the resident called out, "nurse, nurse" and indicated she was having pain. At 10:40 a.m., on 2/15/12, the CNA indicated the resident refused to bathe at this time because she was having too much pain. RN #4 was interviewed at 2:25 p.m., on 2/15/12, and indicated the physician had been called on the first shift regarding the resident's complaints of pain. The RN indicated she didn't know how the resident's hands were washed, but the Restorative Aide was going to talk to the occupational therapist today about the resident's hands. Restorative CNA #5 was Interviewed		following the same schedule listed above. DNS/designee will monitor for compliance.Data will be submitted to CQI committee for review and follow up monthly.The ED will be responsible CQI committee audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Non compliance may result in disciplinary action up to and including termination.	

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	at 2:45 p.m., on 2/15/12, and indicated she was placing splints on the resident's hands everyday, and placed them on in the morning and left them on for 4 to 6 hours. She indicated she had tried to open the resident's hands this morning, but the resident indicated she was having pain. She indicated she had checked "a little bit ago" and tried to clean the resident's hands with a cloth, but as soon as she touched the resident, she indicated she was having hand pain. Restorative CNA #5 indicated the resident's hands had an odor and when she tried to open her hands, the resident indicated they hurt and started crying. Restorative CNA #5 indicated before she would apply the splints to the resident's hands, she would relax them by soaking the resident's hands in warm water with soap, try to stretch her fingers and open her hands, then apply the splints. She indicated the resident was supposed to have this done 6 days a week, but she hadn't done this treatment for 2 days because the resident had been refusing. She indicated she talked to the therapist today and asked her if she could do anything. The restorative aide indicated she told the therapist the resident's hands had an			

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	odor and needed to be cleaned, but the resident was in a lot of pain. She indicated the nurse had just given the resident pain medication. Review of the restorative documentation, provided by the restorative aide, and reviewed with her in attendance, indicated there was no documentation indicating the treatment or splints were completed on 2/7/12, 2/11/12, and a "R" indicating the resident had refused treatment on 2/14/12 and 2/15/12. The restorative aide indicated she had washed the resident's hands on 2/13/12, and applied the splints, but the resident had refused treatment on 2/14/12 and 2/15/12 because the resident was in too much pain. She indicated she had just talked to the therapist and the nurse today about the resident's refusal. Physical Therapist #6 was observed in the resident's room, at 3:10 p.m., on 2/15/12, working with the resident. He indicated he was trying to open her left hand and the reason there was an odor to the hand was because it was contractured, and hard to clean. He indicated the resident complained of pain in the palm of the hand, and it could be due to a nail pressing on the palm of the hand. He			

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	indicated he had started working with the resident last week with his goal including transfers, and mobility. He indicated the resident previously was able to transfer with 1 assist, but now required a 1-2 person transfer assist, mostly two now. The resident record was reviewed, on the afternoon of 2/15/12. Diagnoses included, but not limited to: Alzheimer's Disease, hemiplegia or hemiparesis, Parkinson's Disease, osteoporosis, dysphagia, and Manic Depression. The Minimum Data Set (MDS) assessment, dated 1/16/12, indicated the resident scored 12/15 on the Brief interview for mental status (BIMS), and indicated the resident required extensive to total assist of 1-2 persons for bed mobility, transfer, dressing, eating, and personal hygiene, had upper extremity impairment bilaterally, was incontinent of urine, and was on a scheduled pain management program. Review of the February, 2012, Medication Administration Record (MAR), indicated the resident had been receiving a pain medication, Norco, 7.5-325 milligram tablets, 1 tablet, by mouth, 3 times daily. In addition, the same pain medication			

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	was ordered to be given every 4 hours as needed (PRN) for moderate to severe pain. The MAR for February, 2012, indicated the PRN medication had been given at 2:00 p.m., on 2/15/12 for hand pain, and twice on 2/16/12, for hand pain, and hand and hip pain. Review of nursing progress notes indicated the following: 1/10/12 thumbnails were trimmed due to cutting into resident's palms; (there was no further documentation in the nursing notes of further nail care) 2/1/12 denies pain and discomfort to bilateral hands; 2/15/12 resident complained of general pain to the left arm and chronic pain to bilateral hands, and resident claimed only slight effectiveness as a result of routine pain medication; physician notified of above; 2/16/12 at 6:44 a.m., complained of hands hurting, pain pill given , effective after one hour; 2/16/12 at 8:00 a.m., resident complained of pain in bilateral hands, routine pain medication given at this time; 2/16/12 at 9:00 a.m., resident indicated pain medication did not help pain in hands. Resident would not			

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	allow nurse to assess hand; 2/16/12 at 10:15 a.m., notified by therapy of open area to resident's left palm. Observed open area to center of left palm, pink in color with white moist periwound. Resident required coaxing and encouragement to allow the therapist to open her hand; 2/16/12 at 10:15 a.m., went to resident to assess and trim fingernails, resident would not open hand for assessment; 2/16/12 at 10:30 a.m., physician notified of open area to left hand. Resident still refusing assessment, but stated pain was less now; 2/16/12 at 2:00 p.m., Resident allowed nurse to wash and dress area on left hand. Dry sterile gauze placed to prevent thumb from irritating area. Review of a pressure sore risk assessment, completed on 1/16/12, indicated the resident did not refuse care, the resident was confused or had memory problems, no history of pressure sores, and the resident had impaired or decreased mobility, Review of weekly skin assessment reports indicated skin assessments were completed most recently on 2/3/12 and 2/10/12, with no open areas noted.			

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	Review of a therapy screening, dated 10/13/11, indicated the resident required extensive assist for activities of daily living, including feeding and hygiene, the bilateral hands were contractured and range of motion(ROM) impaired, and the resident was at high risk for hand hygiene. Occupational therapy documentation indicated service was discontinued on 2/1/12, and restorative staff educated on current splint and ROM program. The discharge summary indicated the resident responded to therapy and tolerated the bilateral static hand splints and restorative ROM program. Care plans were reviewed and indicated the following: Self care deficit related to dementia and Parkinson's (problem start date of 5/16/11); approaches included, but not limited to: Restorative nursing as indicated for maintenance of functional status; Chronic back and hand pain (problem start date of 5/16/11) Approaches included, but not limited to: observe for changes in day to day activities; Resident required passive range of motion to bilateral hands, wrists due to contractures (problem start			

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	date of 2/1/12). Approaches included, but not limited to: resident would tolerate 20 repetitions of passive range of motion to bilateral hands and wrists 6 days weekly after warm hand soaks; Resident required splint/brace program (problem start date of 2/1/2012) Approaches included, but not limited to: notify nurse if resident had signs of pain or had skin irritation under splint; observe skin for redness or irritation under splint; resident would tolerate wearing bilateral static hand splints for 4 hours 6 days weekly; Resident at risk for skin breakdown due to incontinence and decreased mobility (problem start date of 5/16/11). Approaches included, but not limited to: assess and document skin condition weekly and as needed. The Certified Occupational Therapy Assistant (COTA) #2 was Interviewed at 9:24 a.m., on 2/16/12. She indicated she had been treating the resident for months for hand contractures, and she was discharged from therapy as of 2/2/12 because she had reached the goals with splints, tolerating 4-6 hours a day. She indicated the resident had severe rheumatoid arthritis. She indicated			

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	the restorative aide talked to her yesterday and informed her the resident had refused to wear the splints. The COTA indicated while the resident was in therapy, she was able to open her hands actively enough to wear the splints and she had never refused to wear them before. She indicated she saw the resident on 2/15/12 after talking to the restorative aide, and the resident told her she was in too much pain to wear the splints. She indicated the resident's hands had an odor and If necessary she would put her back on the caseload. She indicated this was completely a new thing with the resident refusing to wear the splints. She indicated she offered to soak the resident's hands, but the resident refused. She indicated the hands would smell after one day if the hands were not soaked. The COTA was observed in the resident's room, at 9:55 a.m., on 2/16/12, cleaning the resident's hands. The resident was noted to attempt to open her hands when requested by the COTA. When she was cleaning the resident's left hand, the resident indicated her hand hurt, and when the COTA opened her left hand, she indicated there was an			

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	open sore in the mid palm of the left hand. The COTA indicated the resident's left thumb was contracted all the way in to the palm. At this time, the open area was observed in the middle of palm of hand where the thumb nail had been pressing. The thumb nail was also long and needed to be trimmed. The COTA indicated the area was moist and odorous. Review on the morning of 2/17/12, of the therapy screening, dated 2/16/12, and completed by COTA #2, indicated the resident had refused splint application and hand hygiene for restorative for 2 days. The COTA convinced the resident to let her clean and do passive range of motion (PROM) to the digits and wrists. Upon cleaning and performing PROM to left hand contracture, the COTA noticed a wound on the middle of the palm. Occupational therapy recommended restorative continue right hand hygiene and splint application and left orthotic use on hold until the wound healed. The note indicated nursing dressed the wound and a carrot-shaped palm protector was placed in the left hand to decrease pressure from the thumb touching the wound.			

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	Review on the morning of 2/17/12, of a pressure wound skin evaluation report, dated 2/16/12, indicated a new stage 2, pressure area was noted on Resident #2's left palm. The area measured 0.7 x 1.0 centimeters, was pink with a white moist periwound, small amount of serous drainage, and a slight odor. A physician's order, dated 2/16/12, at 2:00 p.m., indicated an order for Xeroform and a dry sterile dressing to the left hand to be changed daily. Review of the Skin Management Program, with the original date of 3/10, and provided by the medical records LPN, on 2/17/12, at 8:50 a.m., indicated weekly skin assessments would be completed on all residents with or without alterations in skin integrity and documented on the weekly skin assessment form and/or nursing notes. 3.1-40(a)(1) 3.1-40(a)(2)			

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F0371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure staff washed their hands for the appropriate amount of time and used a paper towel to turn off the water faucet potentially affecting 9 of 9 residents who ate in the Memory Care dining room and 26 of 28 residents (including Resident #26) who ate or were fed their meals in the second floor dining room. The facility also failed to ensure staff did not handle food from a resident's meal tray with bare fingers before giving it to the resident to eat (Resident #61) potentially affecting 1 of 4 residents who ate in the assisted dining room. Findings include: 1. During an observation of the lunch meal in the Memory Care dining room on 2/13/12 at 11:43 a.m., nine residents were observed seated in the Memory Care dining room. Two staff were observed passing lunch trays to the residents. Certified	F0371	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** CNA #14, #9, #15, LPN #15 re-educated and LPN# 15 is no longer employed at facility.All staff in-serviced on proper hand washing and proper serving protocol to maintain safety and sanitary conditions while dining.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents served by staff are at risk for this deficiency. Staff will identify residents at risk daily during dining services by being present in dining room and Licensed nursing staff monitoring for any risk factors and alerting DNS/ or designee and Dietary Manager. **What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?** All staff members including nursing staff and department managers will be	03/18/2012

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	Nursing Assistant (CNA) #14 was observed to wash her hands for 15 seconds and did not use a paper towel as a barrier when turning off the water faucet. She directly proceeded to serve lunch trays to residents. At 11:50 a.m., CNA #14 was observed to wash her hands for only 10 seconds and resumed passing lunch trays to residents. 2. During an observation of the lunch meal in the second floor dining room on 2/13/12 at 12:25 p.m., three facility staff were observed passing lunch trays to the 26 residents who ate their meals in the second floor dining room. After passing several lunch trays, CNA #9 was observed to wash her hands for 5 seconds and did not use a paper towel as a barrier when turning off the water faucet. She directly proceeded to feed Resident #26 who required total assistance at mealtime. 3. During an observation of the lunch meal in the assist dining room on 2/15/12 at 12:10 p.m., LPN #15 was observed feeding Resident #61 who required total assistance at mealtime. As indicated on review of the Fall/Winter 2011-2012 menu for that meal, the resident received oven browned potatoes. LPN #15 was		re-educated on proper hand washing techniques and serving of food to residents by DNS/designee. Hand washing posters to be hung in all dining-room sink areas. A skill check off list will be conducted with each staff member listed above.All Dining room services will be monitored by a supervisor schedule. Non- compliance will be monitored by DNS/ designee and follow up appropriately.**How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?** A CQI hand washing Log will be monitored by DNS/designee that will monitor the daily x 1 month, twice weekly x 3 months, and weekly x3 months, and then quarterly until cotinued compliance is maintained for two consecutive quarters.Data will be submitted to CQI committee for review and follow up.To ensure compliance. The results will be reviewed by CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.Non compliance may result in disciplinary action up to and including termination.	

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	observed to pick up individual oven browned potatoes with her bare fingers and place then on the resident's spoon before placing the spoon into the mouth of the resident. She was also observed to use her bare fingers to push the oven browned potatoes onto the resident's spoon before placing the spoon into the mouth of the resident. The Assistant Director of Nursing was interviewed on 2/16/12 at 1:37 p.m. During the interview, she indicated nursing personnel were to wash their hands for 20 seconds and use a paper towel to turn off the water faucet prior to assisting residents with meal trays. She also indicated staff were not to use their bare hands to handle food that was served to the residents. A facility policy "Hand Washing Policy & Procedure," dated 1/2010, indicated "...To prevent the spread of infectious disease...When washing hands with soap and water, wet hands first with water, apply soap and rub hands together vigorously for at least 20 seconds...covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet...."			

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	3.1-21(i)(2)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review, and interview, the facility failed to ensure pharmacy and nursing policies were implemented to ensure medications were administered as ordered by the physician for 1 of 24 residents reviewed for following orders in a stage 2 sample of 27 residents (Resident #36). Findings include: The record for Resident #36 was reviewed on 2/14/12 at 2:00 P.M. Diagnoses included, but were not limited to, psychosis.	F0425	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 36 medications were reviewed and discontinued by MD at the time that the deficiency was noted. The resident's Care Plan was reviewed and updated as needed. The DNS reviewed the error with the staff member that failed to capture medication change at the time of admission. All charts were reviewed to compare physician orders with Medication and treatment records for accuracy.**How will you identify other residents having**	03/18/2012

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	A physician's order, dated 12/9/11, indicated Seroquel (medication used to treat psychosis) was increased from 25 mg (milligrams) in the morning and 50 mg at bedtime to 50 mg twice daily (morning and bedtime). The Medication Administration Record (MAR) for Resident #36 for December 2011 indicated the order was changed on 12/9/11 to Seroquel 50 mg twice daily. The MARs for January 2012 and February 2012 indicated the resident was to receive Seroquel 25 mg in the morning and 50 mg at bedtime. Nurse #24 was interviewed on 2/15/12 at 9:15 A.M. During the interview, the nurse indicated Resident #36 was to receive Seroquel 25 mg in the morning and 50 mg at bedtime. The nurse provided Resident #36's Seroquel packages from the medication cart. The labels on the packages indicated the dose of the Seroquel tablets as 50 mg. One package contained whole tablets of Seroquel and one package contained tablets that had been cut in half. The instructions on the labels indicated the resident was to be administered a		**the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents are at risk for deficiency. Staff will be educated on the proper transcription process and the Monthly Rewrite process. **What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?** DNS/designee will re-educate nurses on re-write process. All licensed nursing staff will be in-serviced on new protocol. A post test will be given during in-service.**How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?** A CQI Medication Transcription Log will be monitored daily x 1 month, twice weekly x 2 months, and weekly x3 months, ending with periodic checking as needed for compliance by DNS/designee.Monitoring will be done daily by nursing management team to verify new orders are faxed and processed by pharmacy correctly. Data will be submitted to CQI committee for review and follow up on a monthly basis. The ED will be responsible CQI committee audits. If threshold of 95% is not achieved an action plan will be developed to ensure	

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	half tablet (25 mg) of Seroquel in the morning and a whole tablet of Seroquel (50 mg) at bedtime. The facility Assistant Director of Nursing (ADON) was interviewed on 2/15/12 at 9:45 A.M. During the interview, the ADON indicated Resident #36 had previously been prescribed Seroquel 25 mg in the morning and 50 mg at bedtime, but the order had been changed by the physician to Seroquel 50 mg twice daily on 12/9/11. The ADON further indicated the order had been changed to Seroquel 50 mg twice daily on the December 2011 MAR, but the change had not been carried over to the January 2012 and February 2012 MARs. The ADON indicated the January 2012 and February 2012 MARs should have been checked by nursing staff and compared to the orders in the chart to ensure all of the orders were accurate. The ADON indicated she did not know why pharmacy had continued to send the wrong dose of the Seroquel to the facility and could not indicate if nursing staff had notified the pharmacy of the order change. An undated facility policy entitled "Medication Administration" was provided by Nurse #7 on 2/17/12 at		compliance. Non compliance may result in disciplinary action up to and including termination.	

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	11:00 A.M. The policy indicated "The MAR (medication administration records) are to be verified with the physician's orders at least monthly." 3.1-25(a)			

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F0456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure call lights in resident rooms were functioning for 2 residents in a sample of 40 residents reviewed for call light function. (Resident #1 and Resident #44) Findings include: 1. The call lights for the beds in occupied room 211, where Resident #1 and Resident #44 resided, were checked for proper functioning at 11:48 A.M.,on 2/13/12. Both of the call lights lit up on the light indicator on the wall in the residents' room: however, the call light indicator above the door outside of the residents' room did not light up when the call lights were activated. The emergency call light in the residents' bathroom also lit up in the bathroom, but did not light up above the door outside of the residents' room. LPN #19 came to the residents' room, at 11:50 A.M., on 2/13/12, and indicated she was in the nurse's station (located on the other	F0456	It is the intent of this community to have all essential equipment, safe and in operating condition. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The call light outside room 211 was replaced and verified in working order after replacement by the maintenance and nursing department. The call light cord and call button for resident # 44 was replaced at the time of notification. The maintenance department verified that it was in working order and easy for the resident to operate. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**Nursing staff will check call lights daily x 3 month, weekly x 3 months and then quarterly until compliance is maintained for 2 consecutive quarters.**What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?** The director of Maintenance will conduct an in-service for all staff regarding	03/18/2012

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	hallway) and the panel in the nurse's station lit up indicating the call light had been activated in Room 211. The LPN confirmed the light indicator above the door on the outside of the room did not light up when the call lights in the room were activated and she would have it checked. In addition, the call light for Resident #44 was very difficult to turn on and had to be depressed several times before the light activated. Review of the February 2012 "Verify Proper Operation" forms, provided by the Assistant Director of Nursing Services, on 2/16/12, at 12:16 P.M., indicated the nurse call system was checked on 2/6/12 and 2/13/12 for proper functioning. Maintenance Assistant #18, was interviewed, on 2/17/12, at 9:50 A.M., and indicated the bulb was replaced in the call light indicator outside the residents' door. 3.1-19(bb)		equipment in safe operating order and the importance of notifing management when it is not.**How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?** The maintenance director and or appointment staff member will be conducting weekly verification of all call lights to ensure that they all are in working order. This will be part of the weekly preventative maintenance program as well as the safety program.DNS/designee will use the Call Light CQI Tool to ensure compliance with daily call light system functionality check. Data will be submitted to CQI committee for review and follow up monthly.The ED will be responsible CQI committee audits. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. Non compliance may result in disciplinary action up to and including termination.	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review, and interview, the facility failed to ensure medication orders were correctly transcribed on to the Medication Administration Record (MAR) for 1 of 24 residents reviewed for transcription of orders in a total sample of 27 residents (Resident #36). Findings include: The record for Resident #36 was reviewed on 2/14/12 at 2:00 P.M. Diagnoses included, but were not limited to, psychosis. A physician's order, dated 12/9/11, indicated Seroquel (medication used to treat psychosis) was increased from 25 mg (milligrams) in the morning and 50 mg at bedtime to 50	F0514	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 36 medications were reviewed and discontinued by MD at the time that the deficiency was noted. The resident's Care Plan was reviewed and updated as needed. DNS reviewed error with the staff member that failed to capture medication change at admission. All charts were reviewed to compare physician orders with Medication and treatment records for accuracy.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents are at risk for deficiency. All nursing staff will be re-educated on proper transcription process and the Monthly Rewrite process. **What**	03/18/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 00 B. WING	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	mg twice daily (morning and bedtime). The Medication Administration Record for Resident #36 for December 2011 indicated the order was changed on 12/9/11 to Seroquel 50 mg twice daily. The MARs for January 2012 and February 2012 did not reflect the change in orders and indicated the resident was to receive Seroquel 25 mg in the morning and 50 mg at bedtime. The facility Assistant Director of Nursing (ADON) was interviewed on 2/15/12 at 9:45 A.M. During the interview, the ADON indicated Resident #36 had previously been prescribed Seroquel 25 mg in the morning and 50 mg at bedtime, but the order had been changed by the physician to Seroquel 50 mg twice daily on 12/9/11. The ADON further indicated the order had been changed to Seroquel 50 mg twice daily on the December 2011 MAR, but the change had not been carried over to the January 2012 and February 2012 MARs. The ADON indicated the January 2012 and February 2012 MARs should have been checked by nursing staff and compared to the		**measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?** DNs/designee will re-educate nurses on re-write process. All licensed nursing staff will be in-serviced on new protocol. A post test will be given during in-service.**How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?** A CQI Medication Transcription Log will be monitored daily x 1 month, twice weekly x 3 months, and weekly x3 months, ending with quarterly checks until continued contininued compliance is maintained for 2 consecutives quarters. Monitoring will be done daily by nursing management team to verify new orders are faxed and processed by pharmacy correctly. Data will be submitted to CQI committee for review and follow up monthly.The ED will be responsible CQI committee audits. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Non compliance may result in disciplinary action up to and including termination.	

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	orders in the chart to ensure all of the orders were accurate. An undated facility policy entitled "Medication Administration" was provided by Nurse #7 on 2/17/12 at 11:00 A.M. The policy indicated "The MAR (medication administration records) are to be verified with the physician's orders at least monthly." 3.1-50(a)(1)			